STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555702	A. BUILDING _____ B. WING _____	09/28/2007

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Bakersfield Healthcare Center	**730 34TH STREET, BAKERSFIELD, CA 93301 KERN COUNTY**

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	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Representing the Department of Public Health: [redacted], Health Facilities Evaluator Nu CLASS AA CITATION -- PATIENT CARE 12-2073-0004404-S Complaint(s): CA00119691 72311(a)(1)(A) Nursing Service - General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission. On July 19, 2007 at 9 AM, an unannounced visit was made to the facility to investigate a complaint regarding facility staff who failed to monitor a patient (Patient 1) who was on Coumadin (a blood thinner) therapy. Patient 1 expired on October 20, 2006 as a result of a gastrointestinal bleed, within 12 hours after [redacted] transfer to the Emergency Department (ED). Based on interview and record review, the facility failed to: 1. Reassess Patient 1 for adverse consequences			

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	Continued From page 1 when using Coumadin in conjunction with Mobic (a medication that is classified as non-steroidal anti-inflammatory drugs (NSAIDs) and used to treat joint pain). The interactions between these two medications are known to increase PT/INR (Prothrombin Time/ International Normalized Ratio, a test that is used to determine clotting factor and as a standard for monitoring the effects of Coumadin). 2. Reassess for appropriate alternatives when Patient 1 refused PT/INR blood draws. 3. No care plans were developed regarding these concerns. On July 19, 2007 at 8:30 AM, record review was performed for Patient 1. The records indicated an admission date to the facility from a general acute care hospital (GACH) on September 7, 2006, with diagnoses that included atrial fibrillation and back pain. During [redacted] stay at the GACH, [redacted] was on Heparin (a blood thinner) therapy and on Mobic for [redacted] back pain. Both medications were continued after [redacted] admission to the facility. Four days after [redacted] admission, on September 11, 2006, Patient 1's attending physician wrote an order to start Coumadin and discontinue Heparin on September 21, 2006. The Coumadin order read: "Coumadin 2.5 milligrams (mg) q hs (every day at bedtime). Check PT /INR in am (morning) and q (every), Monday hold Coumadin if INR > 3.0." A facility staff nurse transcribed the order onto the Medication Administration Record (MAR) as "Coumadin 2.5mg one tab (tablet) po (by Mouth) q hs" and "PT/INR next Mon (Monday)." This order, transcribed onto the MAR, did not include the			

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	Continued From page 2 indications for the use of Coumadin; nor the subsequent orders: “check PT/INR every Monday” and “hold Coumadin if INR is greater than 3.0.” Staff 1 documented on September 18, 2006, at 1:50 PM, “Dr…called regarding lab (laboratory) work done on September 12, 2006, INR 0.87. New order to increase Coumadin…” On September 18, 2006, a telephone order from the physician read: “Increase Coumadin to 5 milligrams po q hs”. The Coumadin dosage was doubled, from 2.5 milligrams to 5.0 milligrams. Staff 1 did not include “check PT/INR every Monday” and “hold Coumadin if INR was greater than 3.0” onto the MAR. At 9:10 AM, review of Patient 1’s clinical record for weekly PT/INR results, the only results available were dated September 12, 2006. On July 19, 2007 at 2:25 PM, Patient 1’s Weekly Nursing Summary, dated October 19, 2006, was reviewed. Staff 1 documented on September 21, 2006 that Patient 1 refused laboratory blood draws which was the day of [redacted] transfer to the ED and 28 days after [redacted] blood draw refusal. On the same documentation, Staff 1 wrote that he informed Patient 1’s attending physician of the refusal and received an order to change the PT/INR from weekly to monthly; the next draw was scheduled to be done October 23, 2006. However, Staff 1 failed to write the new order for laboratory blood draws on the physician’s order form, failed to document that a reassessment of [redacted] refusal of the blood draws were documented on the nurses’ notes, and failed to update the care plan regarding [redacted] refusals. On July 29, 2007, at 4:40 PM, during an interview			

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	Continued From page 3 with both the Director of Nurses (DON) and Staff 1, they both confirmed this[DGG1]. Staff 1 stated he did not ask Patient 1 the reason for [redacted] refusal of the PT/INR blood draws, because, "I was not on duty at the time. I found out [redacted] refusal later." The night shift nurse, no longer employed at the facility, did not relay the information to Staff 1 regarding Patient 1's refusal of blood draws. On July 29, 2007, at 4:45 PM, further record review was performed. The facility consulting pharmacist made a scheduled visit on October 5, 2006 and documented on the consultation report, "…this individual has been identified as taking Warfarin (Coumadin) and Meloxicam (Mobic) concomitantly. A study has shown a 13-fold increase in the risk of developing hemorrhagic peptic ulcer (gastric ulcer) disease in concurrent users of oral anticoagulants and NSAIDs. Mobic is recommended to be used with extreme caution in individuals taking oral anticoagulant therapy." The consulting pharmacist recommended to: "1. please consider the need for routine Mobic therapy, perhaps considering a non-NSAID alternative such as acetaminophen (known as Tylenol) or tramadol (ultram, used for pain management); 2. Please add a supporting diagnosis for Coumadin." Recommendation 1 was not acted upon until the day of [redacted] transfer to the general acute care hospital. Recommendation 2 was never acted upon. On the pharmacy consultation report, the pharmacist made references related to her recommendations. The report read, "Concurrent use of NSAIDs and oral anticoagulants places elderly persons at high risk for hemorrhagic peptic ulcer disease (gastric			

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	Continued From page 4			

ulcer)." No documentation could be found in [redacted] Pharmacy Consultation Report dated on October 5, 2006 to address unavailable PT/INR results nor Resident 1's refusal of the PT/INR blood draws; the drug regimen review did not address these concerns. Patient 1's physician responded to the pharmacy recommendation; however the patient refused to change from the Mobic. However, no evidence was found that nursing staff reassessed the patient or offered risks versus benefits of changing the medication.

On September 28, 2007 at 4:55 PM, the facility's "Patient Transfer and Referral Record" dated October 19, 2006 was reviewed. Patient 1 was transferred to ED for "Hypotension, Bloody Stool."

On July 19, 2007 at 11:25 AM, the ED medical record was reviewed. The laboratory results revealed that Patient 1's PT was 109.6; reference was between 11.8 and 14.7, nine times higher than normal. [redacted] INR result was 15.99, eight times higher than the conventional therapy. Patient 1 required resuscitation on October 20, 2006 at 3 AM. [redacted] was declared dead 15 minutes into the resuscitation, 12 hours after the transfer to the emergency room. The ED physician in charge of the resuscitation documented "…It is certain that the patient has essentially bled out through [redacted] GI (gastrointestinal) tract and attempts at further resuscitation are futile." Patient 1 died within 12 hours after being transferred to an ED from the facility.

On August 1, 2007, at 11:10 AM, the consulting

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	Continued From page 5 pharmacist was interviewed in regards to alternative measures the facility could have taken to address Patient 1's refusal of laboratory blood draws. She stated that the facility licensed staff should have tried to convince Patient 1 to continue the PT/INR monitoring. Asked what would be appropriate alternatives if Patient 1 insisted not to have blood draws, the consulting pharmacist stated, "The licensed staff should have informed [redacted] physician and changed the Coumadin to Aspirin or Plavix (a blood thinner)." On July 29, 2007, at 4:45 PM, Patient 1's anticoagulant therapy care plan was reviewed. The interdisciplinary team identified two concerns on September 20, 2006. They were: "Coumadin 5 milligram po qhs," and "Heparin 5,000 units sq (subcutaneous) qd (daily) x 2 weeks." These two medications were given concurrently from September 11 to September 20, 2006. When Patient 1 refused PT/INR, the facility failed to identify the significant risks for potential hemorrhagic peptic ulcer and the significant adverse consequences from medication interactions between Coumadin and Mobic. The "Approach Plan" on this care plan did not address appropriate interventions to be taken to manage these risk factors or risk versus benefits regarding the blood draw refusals. On September 29, 2007 at 4:45 PM, during an interview with the DON, when asked if the care plan should have been revised, he confirmed that Patient 1's care plan should have been updated when [redacted] refused the blood draws.			

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	Continued From page 6 On November 14, 2007, at 10:20 AM, the facility's "Policy and Procedure on Care Plans" was reviewed. Under "Procedure," it read, "11. Documentation in the resident's clinical record should include the following information: a) Identification of reason or cause of treatment refusal…c) Alternative methods or means to address resident's problem or need." There was no evidence found in Patient 1's care plan that facility staff followed this Policy and Procedure to address the refusal of PT/INR and the use of Mobic as major risk factors in Patient 1's plan of care. On June 13, 2008 at 12:25 PM, the facility's "Refusal of Treatment or Medical Procedures" policy and procedures was reviewed. Under the "Policy" statement, it read, "Facility shall determine probable cause(s) of refusal to treat and offer alternatives within the limits of resident's medical condition." Under the Procedures, it read, "6. If resident and/or ...refuses treatment and/or medical procedures, every effort shall be exerted to determine reason(s) of refusal;" and "10. If resident and/or family/responsible party/surrogate decision-maker refuses treatment or medical procedure, offer alternatives to prescribed treatment or procedure." The facility failed to 1) document the clinical reason for using Coumadin on the Care Plan or the Medication Administration Record, 2) revise plan of care to reflect appropriate interventions and monitoring before continuing Coumadin therapy , 3) exert every effort to determine cause(s)/reason(s) of			

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	Continued From page 7 Patient 1's refusal of PT/INR; and, 4) offer alternatives to the prescribed treatment or risks of continuing the Mobic with the Coumadin. The violations presented an imminent danger that death or serious harm to the patient would result and were a direct proximate cause of the death of the patient.			

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.